Medically unexplained symptoms in secondary care

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Medically unexplained symptoms in secondary care

Consider the possibility of anxiety or depression—or simply distress

The efficient use of medical resources is important, so the findings of Reid et al in this issue (p 767) are timely, highlighting the previously undocumented number of frequent attenders at secondary care consultations with medically unexplained symptoms. However, this study raises concerns other than economic ones: there appear to be large numbers of patients whose frequent attendance suggests distress that is neither appropriately identified or addressed.

The reasons for frequent attendance by such patients are undoubtedly complex. At least for the first consultation, attendance may reflect the referral patterns of general practitioners. Medically unexplained symptoms are very common in primary care, but primary care physicians seem to have considerable discomfort in managing these patients. Any patient whose symptoms cannot be explained raises the concern, “What am I missing?” Compounding this unease is the expectation or demand of the patient for a specialist opinion, against a background of increasing litigation.

To clarify the nature of these patients’ problems it is necessary to adopt a more critical analysis of each patient’s health. A recent study showed that the way in which patients describe their symptoms influences patient’s health. A recent study showed that the way in which patients describe their symptoms influences patient’s health. A recent study showed that the way in which patients describe their symptoms influences patient’s health. A recent study showed that the way in which patients describe their symptoms influences patient’s health. A recent study showed that the way in which patients describe their symptoms influences patient’s health. A recent study showed that the way in which patients describe their symptoms influences patient’s health.

Before we collectively sigh and refer these difficult patients to the psychiatric service it is worth pondering our own contribution to the problem. The tendency to conceptualise medical problems in biological terms is powerful, and medical practitioners are often reluctant to explore the non-biological aspects of a patient’s case. In part this may reflect concerns about inadequate training, fear of being unable to help, or the conviction that no psychological interventions would help anyway. Patients respond to the cues offered by health professionals and are themselves part of a culture that continues to stigmatise mentally ill people and those with emotional problems. Hence for a distressed patient it is far more acceptable to present with somatic symptoms.

The need to investigate has the effect of reinforcing concerns about the physical nature of the problem, and this is compounded if the patient sees a new doctor at a subsequent consultation and the tests are repeated “just to be sure.” It becomes clear there are major costs to the healthcare system and the patient.

The challenge by Reid et al to focus on this group of patients is timely, as their levels of disability appear high. One wonders to what extent they contribute to physician exhaustion and stress, given that it is frustrating and annoying to be confronted with patients one cannot help or understand. The fact that a patient returns many times despite being told there is no medical explanation for his or her symptoms reflects continuing distress and concern. Faced with such behaviour health professionals must consider the possibility of depression or anxiety.

In addition they need to pay careful attention to the consultation itself. Patients with somatisation disorders often feel that medical explanations reject the reality of their symptoms, yet those who receive information without blame and are provided with strategies for coping feel empowered. In attempting to help this group of patients we should reflect on our own training, skills, and prejudices as well as broadening our approach to clinical assessment.

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Managing depression in primary care

The type of treatment matters less than ensuring it is done properly and followed up

Several recent studies have evaluated alternative approaches to managing depression in primary care. The range of disease and the treatments examined have varied widely, no doubt contributing to the variation in results. Nevertheless, randomised trials leave little doubt that antidepressant drugs are efficacious in major depression, and recent evidence suggests efficacy in dysthymia and subsyndromal depression as well. But what role does counselling play in the primary care management of patients with various forms of depression? Recent trials in primary care have produced conflicting results and conclusions.

The paper in this issue by Chilvers et al (p 772) and an earlier report from the same study address three important questions about treating major depression in primary care. Is there a difference in the effectiveness of drugs versus counselling? Is the non-standardised counselling provided by most mental health providers effective? Does matching treatment with patient preferences increase effectiveness? In Chilvers et al’s study only the first question is addressed using a randomised design. Unfortunately, small sample sizes and difficulties in follow up urge caution in interpreting the results. Regarding the second and third questions, we must settle for non-experimental comparisons within this sample and with previous reports.

Chilvers et al conclude that generic counselling appears to be as effective as antidepressant drugs for major depression, though patients given drugs may recover more quickly. There may be differences in longer term effects as well. Tables 3 and 4 in the paper show that patients randomised to drugs were 16% more likely to have a “good” global outcome, 10% more likely to ever remit, and 30% less likely to be depressed by research diagnostic criteria. These differences in 12 month outcomes, none of which reached statistical significance, raise a conundrum. Are the differences in outcomes between drugs and counselling in the randomised group large enough to have implications for practice?

Randomised controlled trials on both sides of the Atlantic now provide evidence that different approaches to counselling—cognitive-behavioural, interpersonal, and problem solving—have equivalent efficacy to drugs in treating major depression. But in these studies the “talking therapy” is applied by protocol using specially trained counsellors who are often monitored for adherence to the protocol. Chilvers et al’s study placed few constraints on either the drug treatment or the type of counselling other than that the counselling should be provided by an experienced mental health professional in six sessions. In effect therefore they compared non-standardised antidepressant use with non-standardised counselling by experienced mental health professionals in general practice. Because statistical tests showed no significant differences in effectiveness the authors conclude that generic counselling is effective. Recent comparisons of more rigorously applied non-directive and cognitive-behavioural counselling with usual general practitioner care among a broader range of depressed patients found both specific therapies to be better than usual care at four months but not at 12. This may suggest advantages for more specific, standardised counselling over more generic approaches. Only direct comparisons of generic counselling with more standardised, specific approaches will resolve this question.

As to the implications for practice, the results in the patient preference group may be relevant. Over two thirds of the patients refused randomisation because they preferred a particular form of treatment, and nearly two thirds of them preferred counselling. Both the high proportion of people with a preference and the high proportion of them preferring counselling are consistent with other recent findings. Within the patient preference group there were no differences in outcomes between the groups treated with counselling or drugs. Thus, regardless of one’s interpretation of the randomised results, patient selected counselling or drugs appear to be equally effective if the counselling is provided by an experienced therapist.

It remains possible that patients without preferences will have better long term outcomes with drugs under real world circumstances where follow up may be sporadic. The major differences between usual care and protocol driven care for depression are the assurance of adequate intensity of treatment, whether counselling or drugs, and the consistency of follow up. The low rates of assessment at 12 months in this study illustrate the difficulties with follow up in everyday practice. When care is organised to assure intensity and...